Human Resources/Employee Benefits & Services
DELETING DEPENDENT(S)
Payroll/Personnel Assistant (PPA) Check List & Instructions

Name: _____ SSN: _____

Dept/Div: _____ Position: _____

Health/Dental Insurance Selection Form

It is the PPA's responsibility to ensure that this form is accurately completed.

1. If divorced, please put the final date of decree. The employee must provide you with a copy of the Final Decree of divorce.
2. Enter an effective date for the deletion date (mandatory).
3. Under Eligible Dependents, employee is to indicate relationship, name, and birth date for any dependent that is being deleted.
4. Employee must provide a current mailing address for the dependent that is being deleted.
5. Form must be signed and dated on the back.
6. Send an original and two copies to Employee Benefits & Services; place one copy in the employee's department personnel file.

COBRA Continuation of Health Coverage

Mail a copy of the COBRA letter (City Employees and Families) to the dependent being deleted. Afterwards, prepare a Proof of COBRA Notification Form and place it in the employee's department personnel file.

Certificate of Group Health Plan Coverage (HIPAA) Form

Complete all areas and distribute as follows: original form to dependent; place one copy in the employee's department personnel file.

1. Date you are completing form.
2. Current health and dental plan.
3. Employee's name should go in the space for participant name.
4. Employee's Social Security Number.
5. Name of Dependent to be deleted.
6. City of Long Beach is always the Plan Administrator, your department's name and address.
7. Put your name and phone number as the contact.
8. If the dependent has been covered with no break in coverage for a period of 18 months or longer, check the box on number 8 and skip numbers 9 and 10.
9. If the dependent has not been covered or has a break in coverage during the last 18 months, complete numbers 9 and 10.
10. Line 12 should be completed as appropriate.

COBRA Election Form

If the dependent elects to enroll in COBRA, you must complete all areas of the COBRA Election Form and forward it to the dependent.

1. Complete the name, address, social security number and phone number of the employee (not the dependent's) on the top lines.
2. List the existing health/dental plans, type of qualifying event, and date of qualifying event.
3. Under the Effective Date COBRA Coverage Begins, this date is always the first day of the month following the qualifying event.
4. Skip down to Continue Coverage For Spouse/Child and check the appropriate line.
5. Enter the date coverage ends, which must be 36 months from the date that COBRA begins.
6. Enter the dependent's name, social security number, and address under Eligible Applicant's name.
7. Enter the monthly amounts (from the yearly COBRA rate chart you are given) and ensure that you have indicated the health/dental plans.
8. Sign and date the bottom of the form.
9. Forward this form to the dependent, along with instructions that they need to indicate if they wish to continue or not with the plans. Also, please indicate that they need to circle with or without dental insurance.
10. When you receive the form back from the dependent, forward it to Employee Benefits & Services.